		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		157592	B. WING		12/13/2012	
NAME OF P	PROVIDER OR SUPPLIEF		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOI I EIEI			ROADWAY STE 1		
LMR IND	IANA HOME CARE	EINC	MERRI	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	1	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
G0000						
GUUU	extended survey Survey dates: 12 Facility: 011122 Medicaid #: 200 Surveyor: Ingrid Skilled unduplic LMR is preclude home health aide competency eva period of two (2) 12/19/12 to 12/1 out of compliant Participation 42 Nursing Service Quality Review: RN	2/10/12 - 12/13/12 3 0857640 d Miller, RN, PHNS rated census: 160 patients ed from providing its own the training and/or luation program for a 1) years beginning 19/14 due to being found 1) years beginning 10/14 due to being found 10/15 ce with the Conditions of 10/16 CFR 484.30 Skilled	G0000	LMR Indiana Home Health, IN will sub-contract independent to conduct Aide training and competency evaluation		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

011123

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 01/03/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 157592	A. BUII B. WIN	LDING	00	COMPLETED 12/13/2012		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 7101 BROADWAY STE 1 MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	

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Facility ID: 011123

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		157592	B. WIN			12/13/	2012
NAME OF B	DOLUBED OF GUIDNIES			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			7101 BF	ROADWAY STE 1		
	IANA HOME CARE			MERRII	LLVILLE, IN 46410		
(X4) ID		FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
		LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCI)		DATE
TAG G0121	484.12(c) COMPLIANCE W PROFESSIONAL The HHA and its accepted professi principles that app furnishing service Based on agency visit observation, record review, ar review, the agence employees follow related to infection (patient #1 and # observations, an implemented and were entered on when they acquire required by agen records reviewed resulting in the p infectious disease family, and staff Findings Regarding infect	staff must comply with ional standards and oly to professionals in an HHA. If document review, home interview, clinical and policy and procedure by failed to ensure all wed agency policies on control for 2 of 6 and 4) home visit infection control log was all maintained, and patients the infection control log red an infection as by policy in 5 of 12 and 12 otential to spread es to other patients,	G01	21	The Administrator has inservice staff about Infection Control/Policies & Handwashir Technique. All (communicable diesase or infections) will be entered/reported into a infection control log. The agency policy titled "Standard Precautions " will be reviewed by all Nursing Staff. Tadministrator reviewed the Pol see Exhibit A,B,C,D, A.Infectic Control Policy B.Handwashing Technique C.Standard Precau & Universal Precautions D.Infection Control LogThe Director of Home Heal care services will be responsib for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.For policy Exhibit A,B,C,D, The Administrator ha inserviced Staff 1-2-2013Quali Assurance Nurse will audit reports of Infections entered in Infection Control Log and ensuall cases of infection will be	ng he icy on tion l th le	01/02/2013
		e (HHA) date of hire			recorded in Infection Control L	og	
		was observed to empty			as well as antibiotics.Quality		
		1 2			Assurance will establish continous data monitoring and		
	patient #1's Foley				collecting system to detect		
		500 milliliters of urine			infections.The Director of Hom	e	
	into the toilet. W	Thile emptying the urine			Health care services will be		

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Event ID: SRH111

Facility ID: 011123

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		157592	B. WIN	IG		12/13/	2012
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SOIT EIEF			7101 BI	ROADWAY STE 1		
LMR IND	IANA HOME CARE	EINC		MERRII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	e exit valve of the Foley			responsible for monitoring the corrective actions to ensure th		
		rim of the toilet two			this deficiency is corrected and		
	times. After changing gloves, the aide was observed to don new gloves and not wash her hands.				will not recur.	4	
	On 12/11/12 at 4 PM, the director of nursing indicated home health aide should						
	prevent the Foley bag exit valve from						
	touching the toilet rim and should wash						
	hands after removing dirty gloves and						
	donning clean gloves.						
	2. On 12/12/12	at 11:10 AM, Employee					
	E, Registered Nu	arse (RN) DOH 10/3/07,					
	was observed to	perform wound care on					
	patient #4's lowe	er legs and left foot.					
	Employee E was	s observed to dip the telfa					
	dressing into a s	ilvadene cream container					
	and then applied	this cream and the					
	dressing onto the	e patient's wounds.					
		•					
	a. On 12/13/	12 at 10:30 AM, the					
		ng and Employee E					
		rse should not apply					
		m to a wound by dipping					
		the medicated cream jar					
	_	ig the same dressing to					
	the wound.	0 : 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2					
	b. The agend	cy document titled "Job					
	_	me Health Nurse					
	(Registered Nurs						
		s Implementation					
			1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COM	e survey pleted 3/2012	
	PROVIDER OR SUPPLIER		STREE 7101	ET ADDRESS, CITY, STATE, ZIP (BROADWAY STE 1 RILLVILLE, IN 46410	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	_	- 1				
	Precautions / Un	olicy titled "Standard iversal Precautions" with 8/6/12 stated, "Wash ving gloves "				
	Control" with a r stated, "Infection precautionary me staff, patients / c persons providin acquiring commi- infection and to p	ocedure titled "Infection review date of 8/6/12 a control standards are easures to protect office lients and caregivers (all g patient care) from unicable diseases or prevent transmission or 1. Wash hands after				
		fection control log				
	5. Review of ago evidence an infec	ency documents failed to etion control log.				
	(5/3/12) included certification periand nursing documents hospitalization for tract infection.	d #1, start of care d a plan of care for the od of 10/30/12 - 12/28/12 mentation of or treatment of a urinary Employee B, Registered d a transfer assessment				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/13/2012	
	PROVIDER OR SUPPLIEI		STREET . 7101 B	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
	on 11/22/12, a reassessment on 1 nurse visit note of evidenced the para urinary tract in Cipro. This and not logged in an 7. Clinical reconstituted a plan of certification per 1/16/2013 that in profile updated of with an order for applied to the afflower extremities covered with no and secured in part dressing change every day after of saline with a state infection was not control log. 8. Clinical reconstituted a plan of certification per that included a plan of certification per that included a reconstituted of 11/22/12 with 500 mg (milligray with a start date of 11/29/12. The	esumption of care 1/28/12, and a skilled on 11/28/12 which attent had been treated for affection with the antibiotic abiotic and infection were infection control log. rd #4, SOC 5/22/12 of care for the field of 11/18/12 - included a medication on 10/10/12 and 11/18/12 or silvadene cream to be affected areas (bilateral areas). The cream was to be in-stick pads and kerlix lace with tape. This was to be completed cleaning with 0.9 normal art date of 10/10/12. This of logged in an infection ard #5, SOC 11/9/12,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592		(X2) MULTIPLE CO	00	СОМ	E SURVEY PLETED 3/2012	
	PROVIDER OR SUPPLIER		7101 B	ADDRESS, CITY, STATE, ZIP CO ROADWAY STE 1 LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	9. Clinical reconsincluded a plan of certification period with an order for cream 1 % to be RUQ (right upper cleansing with ward to leave oper documentation in regarding this in 10. Clinical reconsincluded a plan of certification period that evidenced a for Cephalaxin 5 for 10 days on 10 was not logged in 11. On 11/12/12 nursing indicated been developed on 12. The agency control " with a stated, "Agency continuous data system to detect infection control 13. The agency property of the program 8/6/12 stated, "Tental Program 8/6/12 stated," The certification period of the program 8/6/12 stated, "Tental Program 8/6/12 stated," The certification period of the program 8/6/12 stated, "Tental Program 8/6/12 stated," The certification period of the program 8/6/12 stated, "Tental Program 8/6/12 stated," Tental Program 8/6/12 stated, "Tental Program 8/6/12 stated," T	of #6, SOC 10/24/12, of care for the od of 10/24/12 - 12/22/12 resilver sulfadiazine applied to excoriation on er quadrant) after with hydrogen peroxide in to air. There was no in an infection log fection. Ord #12, SOC 9/7/12, of care for the od of 9/7/12 - 11/5/12 physician's verbal order 100 mg four times a day 10/18/12. This infection in an infection control log. Other at 3 PM, the director of in the infection log had for used. Ord #12 infection review date of 8/6/12 will establish a monitoring and collecting infections An log will be maintained."				
	control program	is designed to lower risks				

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		IDENTIFICATION NUMBER: 157592	A. BUILDING B. WING	00	COMPLETED 12/13/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7101 BROADWAY STE 1 MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	patient organizat identification: to identify proble trends. Undesiral further investigat	rates of employee and ion - acquired infections surveillance data is used ems or undesirable ble trends will lead to tion to determine whether rganization acquired a otic review."						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592		A. BUI	LDING	00	(X3) DATE (COMPL 12/13 /	ETED	
	PROVIDER OR SUPPLIER		B. WIN	7101 BF	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 LLVILLE, IN 46410	1	
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
G0143	All personnel furn liaison to ensure to coordinated effect objectives outline Based on intervioral clinical record reto ensure coordinated records reviewed services from other potential to affect services from an arriving services shall matcheir efforts are consumpted and support the consumpted services shall matcheir efforts are consumpted and support the consumpted services shall matcheir efforts are consumpted support the consumpted services shall matcheir efforts are consumpted support the consumpted support the consumpted services shall matcheir efforts are consumpted support the consumpted support the consumpted support supp	olicy titled "Coordination es" with a review date of all personnel furnishing tintain a liaison to assure coordinated effectively objectives outlined in the d#1, start of care (SOC) evidence coordination of her agency or service for d/12 at 10:05 AM, patient nemaker services were	GOT	143	The Director of Nursing has inserviced Nursing Staff 01/02/2012, regarding Coordination of Patient care to maintain a liason to assure the efforts are coordinated effective and support the objectives outlined in the Plan of Care Exhibit E Coordination of Paties Services. Documenting each interaction Director of Nursing also inservice use of case conference, in order to docum coordination of care. The Director of Home Health care services be responsible for monitoring these corective actions to ensithat this deficiency is corrected and will not recur.	eir vely see ent ent tor will	01/02/2013

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157592		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	ie survey ipleted 13/2012	
	PROVIDER OR SUPPLIER		7101 BI	ADDRESS, CITY, STATE, ZIP COD ROADWAY STE 1 LLVILLE, IN 46410)E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	director of nursi medical purpose services. 3. Clinical recordany communicate regarding another home health aide a. On 12/12/ caregiver of patinaide and homem another home health aide are ceiving seagency and it was receiving seagency and it was agency and it was agency and it was agency and it was a connection between blood su through which the hemodialysis. The services is a connection between the connec	/12 at 3:55 PM, the ng indicated there was no for the homemaker at #6 failed to evidence tion or other information or home agency providing to or homemaker service. /12 at 1:45 PM, the ent #6 indicated receiving taker services from eath agency. /12 at 11:05 AM, the ng indicated patient #6 trivices from another as not documented. /13 at 11:05 AM, the ng indicated patient #6 trivices from another as not documented. /14 at 11:05 AM, the ng indicated patient #6 trivices from another as not documented. /15 at 11:05 AM, the ng indicated patient #6 trivices from another as not documented.				
		2 at 2:30 PM, the director ated the patient's record				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COMI	e survey pleted 3/2012		
NAME OF F	ROVIDER OR SUPPLIEF	<u> </u>		ADDRESS, CITY, STATE, ZIP ROADWAY STE 1	CODE			
LMR IND	IANA HOME CARE	EINC	MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
TAG	did not indicate	the skilled nurse had with the dialysis clinic	TAG	DEFICIENCY)		DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		157592	B. WIN			12/13/	2012
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ROADWAY STE 1		
I MR IND	IANA HOME CARE	INC	MERRILLVILLE, IN 46				
(X4) ID		TATEMENT OF DEFICIENCIES	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION
TAG G0144	484.14(g)	LSC IDENTIFYING INFORMATION)		TAG	DLI ICILICE ()		DATE
	COORDINATION The clinical record conferences estal	OF PATIENT SERVICES d or minutes of case blish that effective rting, and coordination of occur.					
	Based on intervio	ew, policy review, and	G01	144	The Director of Nursing will		01/02/2013
		eview, the agency failed			inservice all Skileld Nurses on		
		nation of care occurred			01/02/2013 to document for		
	with other entitie	es providing services for			patients receiving homemaker services from another agency		
		ecord #1 and #6 and #7)			notify agency. The Director of	ana	
	,	of patients receiving			Home Health care services will		
		ner entities with the			responsible for monitoring thes		
		et all patients with the			corrective actions to ensure th		
	-	et all patients receiving			this deficiency is corrected and will not recur. Director of Nursir		
	services from an				Staff has inserviced Nursing	.9	
		other entity.			staff, Skilled Nurses will communicate with the dialysis		
	Findings				facility about the patient care. will review the policy titled	We	
	1. The agency p	olicy titled "Coordination			" Coordination of Patient Servi	ces	
	of Patient service	es" with a review date of			" are coordinated with other	els (
	8/6/12 stated, "A	ll personnel furnishing			facility and documented prope in patients chart weekly. Direct	-	
	services shall ma	nintain a liaison to assure			of Nursing also inservice the s		
		coordinated effectively			on case conference in order to		
		objectives outlined in the			document coordination of		
	Plan of care."				care.The Director of Home He		
					Care services will be responsil for monitoring these corrective		
	2. Clinical recor	rd #1, start of care (SOC)			actions to ensure that this	,	
		evidence coordination of			deficiency is corrected.		
	*	ner agency or service for					
	homemaking.	ici agency of service for					
	nomemaking.						
	a On 12/11	/12 at 10:05 AM, patient					
		nemaker services were					
	provided by anot	tner agency.					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	ie survey ipleted 13/2012
	PROVIDER OR SUPPLIER		7101 BI	ADDRESS, CITY, STATE, ZIP COD ROADWAY STE 1 LLVILLE, IN 46410)E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	director of nursi medical purpose services. 3. Clinical recordany communicate regarding another home health aide a. On 12/12/ caregiver of patinaide and homem another home health aide are ceiving seagency and it was receiving seagency and it was agency and it was agency and it was agency and it was a connection between blood su through which the hemodialysis. The services is a connection between the connec	/12 at 3:55 PM, the ng indicated there was no for the homemaker at #6 failed to evidence tion or other information or home agency providing to or homemaker service. /12 at 1:45 PM, the ent #6 indicated receiving taker services from eath agency. /12 at 11:05 AM, the ng indicated patient #6 trivices from another as not documented. /13 at 11:05 AM, the ng indicated patient #6 trivices from another as not documented. /14 at 11:05 AM, the ng indicated patient #6 trivices from another as not documented. /15 at 11:05 AM, the ng indicated patient #6 trivices from another as not documented.				
		2 at 2:30 PM, the director ated the patient's record				

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Event ID: SRH111

Facility ID: 011123

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	OF CORRECTION	IDENTIFICATION NUMBER: 157592	(X2) MULTIPLE CC A. BUILDING B. WING	00		
LMR IND	ROVIDER OR SUPPLIER	INC	7101 BI	ADDRESS, CITY, STATE, ZIP CO ROADWAY STE 1 LLVILLE, IN 46410	ODE	
	SUMMARY S' (EACH DEFICIEN REGULATORY OR did not indicate to	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) The skilled nurse had with the dialysis clinic	STREET A 7101 BI	ROADWAY STE 1	RECTION OULD BE	(X5) COMPLETION DATE

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Event ID: SRH111

Facility ID: 011123

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED	
		157592	B. WIN			12/13/	2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				ROADWAY STE 1			
I MR IND	IANA HOME CARE	INC			LLVILLE, IN 46410			
			1			,		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
G0158	SUPER Care follows a wr established and p	of PATIENTS, POC, MED itten plan of care periodically reviewed by a e, osteopathy, or podiatric						
	medicine.							
	Based on clinical	l record review,	G01	58	Director of Nursing has inservi	ce	01/02/2013	
	personnel file rev	view, and interview, the			nursing staff 01/02/2013, for			
	agency failed to	ensure treatments were			proper documentation that all			
	provided as orde	red on the plan of care			plan of treatment is included in plan of care. And plan of care			
	•	ds reviewed (#2 and 4)			be followed and implemented a			
		l to affect all patients of			evaluate patient services base			
	•	it to affect an patients of			upon Physician plan of			
	the agency.				treatment.Nursing Staff were			
	Findings	1 V2			inserviced on proper documentation of wound care the use of Nurses progress notes.Director of Home Helath			
		rd #2, SOC 9/28/12,			Care services will be responsible			
	included a plan o				for monitoring these corrective			
	•	od of 9/28/12 - 11/26/12			actions to ensure that this			
	that failed to evid	dence orders for oxygen			deficiency is corrected and will			
	saturation monito	oring that was			not recur. The Director of Nursi			
	documented at sl	killed nurse visits.			has inserviced Nursing staff or Principal function of Registered			
		care initial assessment			Nurses, provides Nursing care assigned patients utilizing the			
		and signed by Employee			Nursing process to assess, pla			
		and signed by Employee arse (RN), stated,			implement and evaluate patier			
					services based upon a physicia			
	"Oxygen saturati	ion 96 % ra [room air].			plan of treatment. Responsibili - Implementation provides dire			
	b. A nurse v	visit with a date of 10/2/12			patient care with clinical			
	and signed by Er	nployee B stated,			competence.All Nursing care	vd.		
	"Oxygen saturati				provided should be documented with date and time according to			
	on gon saturati				the plan of treatment and	,		
	0 Om 10/10	/12 at 2:20 DM tha			monitors patient status and			
		/12 at 3:30 PM, the ng indicated the plan of			progress toward planned Administer medications and			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		157592	B. WIN			12/13/2012	
			P. (11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			ROADWAY STE 1		
LMR IND	IANA HOME CARE	INC			LVILLE, IN 46410		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	1	ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		rs for the oxygen			treatments are prescribed by		
		be monitored at skilled			patient Physician.		
		be monitored at skined					
	nurse visits.						
	2 (1: : 1	1.114					
		rd #4, start of care					
	5/22/12 included a plan of care for the						
	certification period of 11/18/12 -						
	1/16/2013, with an order for silvadene						
	cream to be applied to bilateral lower						
	extremities, the	area to be covered with					
	non-stick pads a	nd kerlix, and secured in					
	place with tape. The dressing change was						
	to be completed	every day with the wound					
	_	ith 0.9% normal saline					
	•	on of the new dressing.					
		anges were to start					
	10/10/12.	inges were to start					
	10/10/12.						
	a A alimina	l record document titled					
	l	y Visit Note" with					
		ployee E, dated 12/5/12					
	· ·	he specification if this					
		or P.M.) failed to include					
	*	on that wound care was					
	completed or the	e wound was assessed or					
	measured.						
	b. On 12/13	3/12 at 10:30 AM, the					
		ng indicated the wound					
		npleted on this visit note.					
		1					
	c Personne	l file E, date of hire					
		nced a job description for					
		-					
	_I ноте неан Ni	ırse: Registered Nurse					

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		DENTIFICATION NUMBER: 157592	LDING	00	COMPL 12/13/	ETED
	PROVIDER OR SUPPLIER	INC	7101 BF	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	12/30/07. This jo "Principal functio to assigned patien process to assess, evaluate patient so physician's plan o Responsibilities provides direct pa competence accor treatment, nursing established standa monitors patient's toward planned or medications and t	. Implementation tient care with clinical ding to the plan of				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		157592	B. WIN		-	12/13/	2012
NAME OF B	DOWNER OF CHERT IED				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			7101 BF	ROADWAY STE 1		
	IANA HOME CARE	INC		MERRII	LLVILLE, IN 46410		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
		LSC IDENTIFY ING INFORMATION)		IAG	DLI ICILICE I		DATE
TAG G0159	484.18(a) PLAN OF CARE The plan of care of with the agency's diagnoses, includ services and equiportion of visits, prognosifunctional limitation nutritional require treatments, any sugainst injury, insuring discharge or refer appropriate items. Based on clinical observation, interest the agency failed contained all mesurgical procedure patient received (Clinical record creating the pote agency's patients. Findings 1. Clinical record services from the pote agency's patients. Findings 1. Clinical record services from perithat failed to evice oxygen concentry shortness of bread.	I record review, rview, and policy review, I the plan of care dications, equipment, res, and all services the for 2 of 9 active records #1 and #7) reviewed ntial to affect all of the d. If #1, Start of care (SOC) a plan of care for the od of 10/30/12 - 12/28/12 dence the patient had an ator as needed for use for oth. 12 at 10 AM, patient #1	G01	TAG 59	The Director of Home Health of services has inserviced 01/02/2012 staff regarding politicities and Plan of care developed in consultation with agency staff covers all pertine diagnosis, including mental statypes of services and equipmer required, frequency of visits, prognosis rehab potential, functional limitaions, activities permitted nutritional requirements, medications and treatments any safety measure to protect injury, instructions for timely discharge or referral, and any other appropriate items to include oxygen concentration a surgical procedures, and all services patient received. Staff Nurses were inserviced on completion of Plan of care. All staff were inserviced on corrective actions, and disciplinary actions that will be	the ent aus, ent	DATE 01/02/2013
	was observed to concentrator in the				initated in case of non-compliance.The Director of Nursing will also be responsible		
					for monitoring these corrective		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA (X2) MU			MULTIPLE CONSTRUCTION (X3) DATE SUF		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIT	DDIC	00	COMPL	ETED
		157592		LDING		12/13/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
LMD IND	JANIA LIONE OADE	- INIO			ROADWAY STE 1		
LIVIR IND	IANA HOME CARE	: INC		MEKKII	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	b. On 12/11	/12 at 10:05 AM, patient			actions to ensure that this		
	#1 indicated using	ng oxygen when it was			deficiency is corrected and wi		
		cold outside or if needed			not recur.The Director of Nursi		
	for shortness of breath.				has inserviced Nursing staff fo	r	
	101 SHOTHICSS OF	orcam.			initial assessments and to		
	0 10/11/10 10 00 PM 1				complete initial assessments within 48 hours of referral.The		
		/12 at 3:30 PM, the			Director of Home Health Care		
	director of nursing indicated the oxygen				services will be responsible for		
	use was not on the	he plan of care.			monitoring these corrective		
					actions to ensure that this		
	2 Clinical reco	ord #7, start of care			deficiency is corrected and wil	l	
		d a plan of care for the			not recur.		
		•					
	certification period of 9/10/12 - 11/8/12						
		dence the patient had an					
	arteriovenous (A	AV) fistula in the right					
	arm and received	d hemodialysis 3 days a					
	week.						
	A A clinica	al record document titled					
	_	alt to Case Management"					
		26/12 from a local					
	hospital stated, "	'Renal dialysis status right					
	upper arm AV fi	istula."					
	B. On 8/24/	12 at 3 PM, the director					
		ated the patient was on					
		•					
	1	a dialysis clinic three					
		he plan of care did not					
	address the AV	fistula or the					
	hemodialysis car	re the patient received					
	three times a we	ek.					
	3 The agency n	oolicy titled "Plan of					
		a review date of 8/6/12					
	stated, "A plan o	of treatment is developed	\perp				

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		VIDER/SUPPLIER/CLIA ICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 12/13	
	PROVIDER OR SUPPLIER		7101 BF	ADDRESS, CITY, STATE, ZIP C ROADWAY STE 1 LLVILLE, IN 46410	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMEN (EACH DEFICIENCY MUST REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	for each patient admitte health program in consure ferring physician Teatment includes the information surgical medical supplies and Dimedical equipment] ord available to patient, sign findings."	ultation with the he plan of e following procedures ME [durable lered, and those				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592		LDING	ONSTRUCTION 00	(X3) DATE (COMPL 12/13/	ETED
	PROVIDER OR SUPPLIER		B. WIIV	7101 BI	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 LLVILLE, IN 46410	I	
(X4) ID PREFIX TAG G0168	SUMMARY S' (EACH DEFICIEN REGULATORY OR 484.30 SKILLED NURSII Based on clinical personnel file review, it was failed to ensure to provided treatment plan of care for 2 with the potential the agency receives	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) NG SERVICES I record review, view, policy review, and determined the agency he registered nurse ents as ordered on the 2 of 12 records reviewed I to affect all patients of ving skilled nurse	G01	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) The Director of Nursing has inserviced Nursing Staff for initial assessments and to complete initial assessments within 48 hours of referral. The Director Nursing will also be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Inservice has been made by Director of Nursing, a staff will review policy of Infections.	tial d of le e	(X5) COMPLETION DATE 01/02/2013
	registered nurse patient's arteriov during the initial completed the in 48 hours of refer reviewed with th patients of the ag to ensure the reg infection control care for 1 of 2 w with a skilled nu affect all patients from employee I to ensure the reg care with other e for 3 of 3 (clinical #7) records reviewed with a feet potential to affect potential to affect potential to affect patients of the patients of th	accurately assessed the enous fistula history assessment and itial assessment within ral for 2 of 12 records e potential to affect all gency (See G 171), failed istered nurse followed techniques for wound care observations rese with the potential to serceiving wound care (See G 174), and failed istered nurse coordinated intities providing services all record #1 and #6 and ewed of patients receiving mer entities with the at all patients with the at all patients receiving other entity (See G 176).			control techniques for wound of and ensure Registered Nurse coordinated care with other entities providing services. Director of Nursing with these corrective actions to ensure that this deficiency in correcte and will not recur.	care ill sure	

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		IDENTIFICATION NUMBER: 157592	A. BUILDING B. WING	00	COMPLETED 12/13/2012
	PROVIDER OR SUPPLIER		7101 B	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	problems resulte to be in complian	effect of these systemic d in the agency's inability nce with the condition 42 lled Nursing Services.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/13/2012		
	PROVIDER OR SUPPLIER		B. WIIV	7101 B	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 LLVILLE, IN 46410	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
G0170	in accordance with Based on clinical personnel file relagency failed to nurse provided to the plan of care freviewed (#2 and affect all patients skilled nurse servituded a plan of certification periodical failed to evisaturation monitodocumented at sile. a. A start of visit on 9/28/12 B, Registered Now "Oxygen saturation b. A nurse wand signed by En "Oxygen saturation c. On 12/12 director of nursing care lacked order.	es skilled nursing services the the plan of care. I record review, view, and interview, the ensure the registered reatments as ordered on for 2 of 12 records d 4) with the potential to sof the agency receiving vices. The d #2, SOC 9/28/12, of care for the od of 9/28/12 - 11/26/12 dence orders for oxygen oring that was killed nurse visits. The care initial assessment and signed by Employee carse (RN), stated, ion 96 % ra [room air].	G01	170	Director of Nursing has inser all Skilled Nurses 01/02/201 review policy " Plan of Care stated on G0159 (Page 6 of 22) Staff Nurses were inservand had a 1:1 training on completion of Plan of Care. T Director of Nursing has inserstaff 01/03/2012 to provide of in Plan of Care and should document wound care done visit note with proper documentation of time AM of to indicate the wound care visit completed. Quality Assurance Nurse will be responsible for auditing clinical records 10% quarterly.	3 to ' as iced he viced rders on a PM vas	01/02/2013

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157502	(X2) MULTIPLE CO A. BUILDING	00	CON	TE SURVEY MPLETED 13/2012
		157592	B. WING			13/2012
	PROVIDER OR SUPPLIER		7101 BI	ADDRESS, CITY, STATE, ZIP C ROADWAY STE 1 LLVILLE, IN 46410	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	nurse visits.					
	5/22/12 included certification peri 1/16/2013, with cream to be appl extremities, the non-stick pads at place with tape. to be completed being cleaned with prior to application.	and #4, start of care I a plan of care for the od of 11/18/12 - an order for silvadene ied to bilateral lower area to be covered with and kerlix, and secured in The dressing change was every day with the wound ith 0.9% normal saline on of the new dressing. Inges were to start				
	"Skilled Nursing signature of Empat 9:30 (lacked the time was A.M. of any documentations)	I record document titled (Visit Note" with ployee E, dated 12/5/12 the specification if this or P.M.) failed to include on that wound care was wound was assessed or				
	c. Personne 10/30/07, eviden Home Health Nu	/12 at 10:30 AM, the ng indicated the wound appleted on this visit note. If file E, date of hire aced a job description for arse: Registered Nurse re of Employee E on ob description stated,				

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ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592 A. BUILDING B. WING			COMPLETED 12/13/2012			
ROVIDER OR SUPPLIER		p. ((1))	STREET A	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1		
SUMMARY ST (EACH DEFICIENCE REGULATORY OR "Principal function to assigned patient of the process to assess evaluate patient of the provides direct provides	INC FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) On: provides nursing care Ints utilizing the Nursing In plan, implement and In services based upon a Interest the services based upon a In	B. WIN	STREET A			(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/13/2012		
	ROVIDER OR SUPPLIER		B. WIIV	7101 B	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	A84.30(a) DUTIES OF THE The registered nuevaluation visit. Based on clinical interview, and portailed to ensure the accurately assess arteriovenous fist initial assessment initial assessment referral for 2 of 10 (patient #7 and 9) affect all patients Findings 1. Clinical recording patients Findings 1. Clinical recording patient and stage renal displayed initial assessment patient had a AV the right arm and fistula in the left a. A clinical "Patient # 7 Sout "Emergency room discharge date 9/10/12 and 19/10/14 and 1	REGISTERED NURSE are makes the initial I record review, blicy review, the agency the registered nurse and the patient's tula history during the transport and completed the transport and the patient and to soft a records reviewed the agency. In the patient and the patient are the patient had a set of the patient had a set of the patient and the patient are the patient are the patient and the patient are the patient are the patient and the patient are the pa	GOT	TAG	CROSS-REFERENCED TO THE APPROPRIA	ed ed ial of ng	
	last one 5/24/10 right upper arm.'	history both arms last one					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157592		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMPL 12/13/	ETED	
	PROVIDER OR SUPPLIER		STREET A 7101 BF	ODDRESS, CITY, STATE, ZIP COD ROADWAY STE 1 LVILLE, IN 46410	Ε	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Employee B, the	/12 at 2:30 PM, director of nursing, ial assessment had not fistula history.				
	"Admission" with stated, "The inition Registered Nurse nursing assessment obtain their health within 48 hours of the control o	cy policy titled h a review date of 8/6/12 al visit will be made a e who will make a ent of the patient and h and social history of receiving referral." d #9, Start of care ed a referral on 4/17/12 d comprehensive 20/12.				
	"Admission" with stated, "The initial Registered Nurse nursing assessment obtain their healt within 48 hours of the b. On 12/13 director of nursing director of nursing states."	cy policy titled h a review date of 8/6/12 al visit will be made by a e who will make a ent of the patient and th and social history of receiving referral." //12 at 3:38 PM, the ng indicated the initial not completed within 48				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/13/2012		
	ROVIDER OR SUPPLIER		B. WIIV	7101 BI	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG G0174	484.30(a) DUTIES OF THE The registered nu- services requiring specialized nursir Based on observa- record review, ar agency failed to nurse followed in techniques for w (patient #4) wour a skilled nurse w all patients receive employee E. Findings 1. Clinical recor 5/22/12 included certification perion 1/16/2013, with a cream to be appl extremities, the a non-stick pads an place with tape. to be completed being cleaned wit to application of dressing changes	REGISTERED NURSE arese furnishes those a substantial and any skill. ation, interview, clinical and procedure review, the ensure the registered affection control ound care for 1 of 2 and care observations with ith the potential to affect wing wound care from	G01		The Administrator inserviced a staff for Infection control See Exhibit A. Any infection will be entered in infection log book for proper monitoring of communicable disease or infection. Includes type of surveillance, type of infection, identify source of infection, da infection obtained and follow-u action. Director of Nursing will responsible for monitoring to ensure that the deficiency is corrected and will not recur.	or ta ıp	01/02/2013
	E, Registered Nu	d care on patient #4's					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 00	COMPLET		
THINDTEMIN	or conduction	157592	A. BUILDING		12/13/20	
		107002	B. WING	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			BROADWAY STE 1		
LMR IND	IANA HOME CARE	INC		ILLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)		COMPLETION DATE
TAG		eft foot. Employee E was	TAG	BELLELENCTY		DATE
	_					
	observed to dip the telfa dressing into a silvadene cream container and then apply					
this cream and the dressing to the patient's						
	wounds.	ie dressing to the patient's				
	woulds.					
	3. On 12/13/12 a	at 10:30 AM, the director				
	of nursing and Employee E indicated the					
	nurse should not	apply medication cream				
to a wound by dipping the dressing into						
	the medicated cr	eam jar and then applying				
the same dressing to the wound.						
		procedure titled "Infection				
		review date of 8/6/12				
	•	n control standards are				
		easures to protect office				
	_	lients and caregivers (all				
		g patient care) from				
		unicable diseases or				
		prevent transmission or				
	cross infection."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592			LDING IG	ONSTRUCTION OO ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE : COMPL 12/13/	ETED	
NAME OF P	PROVIDER OR SUPPLIER				ROADWAY STE 1		
LMR IND	IANA HOME CARE	INC		MERRII	LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
G0176	The registered nu progress notes, coinforms the physic changes in the paneeds. Based on interviculinical record reto ensure the registere with other effor 3 of 3 (clinical #7) records revices from other potential to affect potential to affect services from an Findings 1. The agency prof Patient services from an their efforts are of and support the organization of care." 2. Clinical records 5/3/12, failed to care with any other homemaking. a. On 12/11	REGISTERED NURSE are prepares clinical and coordinates services, cian and other personnel of atient's condition and ew, policy review, and eview, the agency failed istered nurse coordinated entities providing services all record #1 and #6 and ewed of patients receiving her entities with the et all patients with the et all patients receiving other entity. Colicy titled "Coordination es" with a review date of all personnel furnishing aintain a liaison to assure coordinated effectively objectives outlined in the et all, start of care (SOC) evidence coordination of her agency or service for	G03	176	Director of Nursing has inserviall staff titled " Coordination of Patient Services " See Exhibit EAll personnel furnishing servishall monitor a liaison to assur their efforts are coordinated effectively and support the objective outline in plan of care. The Director of Nursing a Qulaity Assurance Nurse - will monitor compliance to ensure that this deficiency is corrected and will not recur.	ices re nd	01/02/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		157592	B. WIN	G		12/13/2012
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	KOVIDEK OK SUPPLIER			7101 BF	ROADWAY STE 1	
LMR IND	IANA HOME CARE	INC		MERRIL	LLVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
	provided by anot	ther agency.				
	1 0 10/11	//				
		/12 at 3:55 PM, the				
	director of nursing indicated there was no					
		for the homemaker				
	services.					
	3. Clinical record #6 failed to evidence					
	any communication or other information					
	regarding another home agency providing					
	home health aide or homemaker service.					
	nome hearm arde of nomemaker service.					
	a. On 12/12/	12 at 1:45 PM, the				
		ent #6 indicated receiving				
		aker services from				
	another home he					
	b. On 12/13/	12 at 11:05 AM, the				
		ng indicated patient #6				
		rvices from another				
	agency and it wa	s not documented.				
	4. Clinical recor	d #7, start of care				
		ed the patient had				
	·	isease and a right arm				
	_	V) fistula (surgical				
	,	een the arterial and				
		oply for hemodialysis)				
	·	ne patient received				
	_	here record failed to				
	_	led nurse communicated				
	with the dialysis					
	with the diarysis	rucinty.				
	On 12/11/12	at 2:30 PM, the director				

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157502		A. BUILDING B. WING	00	COMPLETED 12/13/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7101 BROADWAY STE 1 MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	did not indicate t	tted the patient's record the skilled nurse had with the dialysis clinic 's care.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPL	COMPLETED	
		157592	B. WIN			12/13/	2012	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER							
I MD IND		INC			ROADWAY STE 1			
LIVIR IND	IANA HOME CARE	INC		MEKKII	LLVILLE, IN 46410			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
G0224	HEALTH AIDE Written patient ca home health aide registered nurse of professional who supervision of the paragraph (d) of the Based on home winterview, the ag home health aide instructions for 1 observations of paide services (Cl potential to affect health aide services Findings 1. On 12/12/12 a home folder evid care instructions 2. On 12/13/12 a B, the director of	visit observation and ency failed to ensure the had written patient care of 4 home visit patients with home health inical record #5) with the et all patients with home	G02	224	The Director of Nursing inserviced all nurses 01/02/20 Inserviced that all Home Healt Aides have written patient instructions in patient home fol and check the assigned aide if they understand the assignment.Director will be responsible for monitoring the corrective actions to ensure that this deficiency is corrected and will nor recur.	h Ider f sse at	01/02/2013	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/13/2012		
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
G0331	assessment visit care and support for Medicare patie for the Medicare patie for the Medicare I including homebod Based on clinical interview, and possible failed to ensure the accurately assess arteriovenous fissinitial assessment reviewed (patient affect all patients). Findings 1. Clinical reconstruction of the patient of the patie	e must conduct an initial to determine the immediate needs of the patient; and, ents, to determine eligibility mome health benefit, bund status. I record review, the agency he registered nurse sed the patient's tula history during the t for 1 of 12 records t #7) with the potential to sof the agency. The patient had a detes mellitus type 2 and disease. The patient's set failed to document the form (arteriovenous) fistula in the past history of AV arm. The patient had a disease the patient titled definition of the document titled definition of the patient date 9/24/12 and 1/26/12 past surgical se fistula creation multiple thistory both arms last one	G03	331	The Director of Nursing inserviced all nursing staff to completely and accurately assipatient during the initial assessment and properly documented in start of care for See Exhibit F admission PolicyThe Initial assessment by Registered Nurse determine the immediate care and support needs of the patient and for Medicare patients to determine eligibility for the Medicare hom health benefit including home bound status. The Director of Home Health care service will responsible for monitoring the corrective actions to ensure the this deficiency is corrected and will not recur.	rm. y ne e ne be se at	01/02/2013

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	00	(X3) DATE SURVEY COMPLETED	
11112 12111	or condition,	157592	A. BUILDING		12/13/2012
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	R		ROADWAY STE 1	
LMR IND	IANA HOME CARE	EINC		LLVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	2 0 10/11/12				
		at 2:30 PM, Employee B,			
	the director of nursing, indicated the initial assessment had not included the AV fistula history.				
	71 V Histaia mistoi	y.			
	4. The agency p	oolicy titled "Admission"			
	with a review date of 8/6/12 stated, "The				
initial visit will be made a Registered					
Nurse who will make a nursing					
	assessment of the patient and obtain their				
	health and social history within 48 hours				
	of receiving refe	erral."			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/13/2012		
NAME OF P	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1	12/10/	2012
LMR IND	IANA HOME CARE	INC			LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
G0332	either within 48 he hours of the patie physician-ordered Based on clinical review and intervensure the initial completed within for home care or start of care by 1 (#9). Findings 1. Clinical record 4/20/12, evidence with an initial and assessment on 4/2. The agency pwith a review dainitial visit will be Nurse who will reassessment of the health and social of receiving refers. 3. On 12/13/12 and of nursing indicated assessment of the health and social of receiving refers.	ment visit must be held ours of referral, or within 48 nt's return home, or on the distart of care date. Il record and policy view, the agency failed to evaluation was in 48 hours of the referral the physician ordered of 12 records reviewed and #9, Start of care ed a referral on 4/17/12 and comprehensive 1/20/12. colicy titled "Admission" the of 8/6/12 stated, "The one made by a Registered make a nursing e patient and obtain their history within 48 hours	G03	332	All nursing staff were inservice to complete nursing assessment patient within 48 hours of referral for homecare for initial assessment recertification of care. The Initial visit will be made by registered Nurse who will make a nursing assessment of the patient and obtain their he and social history. The Director home Health care services with the responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	ent de f alth r of ill	01/02/2013

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		157592	B. WIN			12/13/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.					
LMDIND	IANIA LIONAE GADE	INO	7101 BROADWAY STE 1 MERRILLVILLE, IN 46410				
LIMR IND	IANA HOME CARE	: INC		MERKII	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
N0000							
			N00	000			
			1,00				
	This visit was for a state home health						
	agency relicensu	re survey.					
	Survey dates: 12	2/10/12 - 12/13/12					
	j						
	Facility: 011123	3					
	racility. 011123	,					
	Medicaid #: 200	0857640					
	Surveyor: Ingric	d Miller, RN, PHNS					
		,					
	Skilled undunlie	ated census: 160 patients					
	Skined undupite	ateu census. 100 patients					
	O 17, D .	I FIL MON DON					
		Joyce Elder, MSN, BSN,					
	RN						
	Dec	ember 19, 2012					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		157592	B. WIN			12/13/	2012
			D. (11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ROADWAY STE 1		
LMR IND	IANA HOME CARE	INC			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG N0470	410 IAC 17-12-1(Home health age administration/ma Rule 12 Sec. 1(m shall be written ar control of commu compliance with a laws. Based on agency visit observation record review, ar review, the agence employees follow related to infection (patient #1 and # observations, an implemented and were entered on when they acquire required by agence resulting in the prinfectious disease family, and staff. Findings Regarding infect 1. On 12/11/12 a home health aided (DOH) 12/7/06, patient #1's Foley	anagement) Policies and procedures and implemented for the nicable disease in applicable federal and state of document review, home applicable, interview, clinical and policy and procedure cy failed to ensure all wed agency policies on control for 2 of 6 (4) home visit infection control log was at maintained, and patients the infection as acy policy in 5 of 12 at (#1, 4, 5, 6, and 12) actential to spread es to other patients, f. cion control policies at 10 AM, Employee F, at (HHA) date of hire was observed to empty	N04		The Administrator has inservice nursing staff for infection contribution handwashing technique, and reviewed policy" Standard Precautions Universal Precautions on 1/02/2013. All infections will be entered/repoinformation and infection contribution of the standard Precautions and Universal Precautions and Universal Precautions Agency establish a continue data monitoring and collecting system to detect infections, an infection control log will be maintained. Director of Home Helath Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	rted ol will em on The	01/02/2013
	into the toilet. W	While emptying the urine					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		157592	B. WIN			12/13/	2012
			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			7101 BF	ROADWAY STE 1		
LMR IND	IANA HOME CARE	INC		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	•	e exit valve of the Foley					
	bag touched the	rim of the toilet two					
	times. After changing gloves, the aide						
	was observed to don new gloves and not						
	wash her hands.						
	On 12/11/12	On 12/11/12 at 4 PM, the director of					
	nursing indicated home health aide should						
	_	y bag exit valve from					
	^						
	touching the toilet rim and should wash						
	hands after removing dirty gloves and						
	donning clean gloves.						
		at 11:10 AM, Employee					
	E, Registered No	urse (RN) DOH 10/3/07,					
	was observed to	perform wound care on					
	patient #4's lowe	er legs and left foot.					
	Employee E was	s observed to dip the telfa					
	dressing into a s	ilvadene cream container					
	_	this cream and the					
		e patient's wounds.					
	diessing onto the	e patients wounds.					
	a On 12/13/	/12 at 10:30 AM, the					
		ng and Employee E					
		rse should not apply					
		m to a wound by dipping					
		the medicated cream jar					
	1	ig the same dressing to					
	the wound.						
	h The agen	cy document titled "Job					
	1	me Health Nurse					
	_						
	(Registered Nurs	-					
	"Responsibilities	s Implementation					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		157592	B. WIN	G		12/13/	2012
NAME OF D	DROVIDED OD GLIDDI IED		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	C.		7101 BF	ROADWAY STE 1		
LMR IND	IANA HOME CARE	EINC		MERRIL	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		patient care with clinical					
	competence according to the plan of						
	treatment, nursing care plan and						
	established standards."						
	3. The agency policy titled "Standard						
		iversal Precautions" with					
		8/6/12 stated, "Wash					
	hands after remo	oving groves					
	4. The agency procedure titled "Infection						
		review date of 8/6/12					
		n control standards are					
	· ·	easures to protect office					
	1 ^ -	lients and caregivers (all					
		g patient care) from					
		unicable diseases or					
		prevent transmission or					
		1. Wash hands after					
	removing gloves	.					
	Regarding the in	fection control log					
		ency documents failed to					
	evidence an infe	ction control log.					
	6 Clinical recor	rd #1, start of care					
		d a plan of care for the					
	` ′	•					
	_	od of 10/30/12 - 12/28/12					
	and nursing docu						
	_	or treatment of a urinary					
		Employee B, Registered					
	Nurse, complete	d a transfer assessment					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157592		(X2) MUL' A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE S COMPL 12/13/	ETED	
	PROVIDER OR SUPPLIER		-	7101 BR	DDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	assessment on 1 nurse visit note of evidenced the para urinary tract in Cipro. This ant not logged in an 7. Clinical reconsincluded a plan of certification peri 1/16/2013 that in profile updated of with an order for applied to the affiliation of the the	od of 11/18/12 - ncluded a medication on 10/10/12 and 11/18/12 r silvadene cream to be fected areas (bilateral s). The cream was to be n-stick pads and kerlix lace with tape. This was to be completed cleaning with 0.9 normal rt date of 10/10/12. This t logged in an infection					

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157592	B. WING		12/13/2012
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				BROADWAY STE 1	
LMR IND	IANA HOME CARE	: INC	MERR	ILLVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE	RIATE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		rd #6, SOC 10/24/12,			
	included a plan of				
		od of 10/24/12 - 12/22/12			
with an order for silver sulfadiazine					
cream 1 % to be applied to excoriation on					
	RUQ (right upper quadrant) after				
cleansing with with hydrogen peroxide					
and to leave open to air. There was no					
documentation in an infection log					
regarding this infection.					
10. Clinical record #12, SOC 9/7/12,					
	included a plan	of care for the			
	certification peri	od of 9/7/12 - 11/5/12			
	that evidenced a	physician's verbal order			
	for Cephalaxin 5	500 mg four times a day			
	_	0/18/12. This infection			
	1	n an infection control log.			
	11. On 11/12/12	2 at 3 PM, the director of			
		d no infection log had			
	been developed	_			
	o com an company				
	12. The agency	policy titled "Infection			
		review date of 8/6/12			
	stated, "Agency				
		monitoring and collecting			
		infections An			
	*	log will be maintained."			
		log will be maintained.			
	12 The agency:	policy titled "Infection			
		policy titled "Infection			
		" with a review date of			
	·	The agency's infection			
	control program	is designed to lower risks			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592		A. BUILDING B. WING A. BUILDING B. WING A. BUILDING B. WING B. WING A. BUILDING B. WING B. WING			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LMR IND	IANA HOME CARE	INC		ROADWAY STE 1 LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	patient organizat identification: to identify proble trends. Undesiral further investigat	rates of employee and ion - acquired infections surveillance data is used ems or undesirable ble trends will lead to tion to determine whether rganization acquired a otic review."			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	DDIC	00	COMPL	ETED
		157592	A. BUI B. WIN	LDING		12/13/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
LMDIND	IANA HOME CARE	INC			ROADWAY STE 1		
LIVIR IND	IANA HUIVIE CARE	INC		MEKKII	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
N0486	410 IAC 17-12-2(,					
	•	ance improvement					
		The home health agency					
	shall coordinate its services with other health or social service providers serving the patient. Based on interview, policy review, and						
			N04	196	The Administrator has inservice	and	01/02/2013
	clinical record review, the agency failed to ensure coordination of care occurred		1102	100	staff on 01/02/2013 on "	eu	01/02/2013
					Coordination of Patient service	es	
					" See Exhibit E. Coordination		
		es providing services for			of Patient ServicesInservice		
	3 of 3 (clinical record #1 and #6 and #7) records reviewed of patients receiving services from other entities with the				includes " all personnel furnish	-	
					services shall maintain a liaison to assure their afforts are		
					coordinated effectively and		
	potential to affect	et all patients with the			support the adjective outlined	in	
		et all patients receiving			the plan of care.The administrator has inserviced the staff on		
	services from an						
	Services mom un	outer entity.			01/02/2013. Review and discu	uss	
	Ein din oa				the agency policy on Coordina		
	Findings				of Care and other services. The		
					importance of coordinating wit		
		olicy titled "Coordination			all disciplines involved in the c and to all other agencies	are	
	of Patient service	es" with a review date of			providing services. The chart a	udit	
	8/6/12 stated, "A	ll personnel furnishing			tool and admission check list	uuit	
	services shall ma	intain a liaison to assure			were revised to include care		
	their efforts are o	coordinated effectively			coordiantion to other agencies		
		objectives outlined in the			providing care, and to all		
	Plan of care."	ojectives outilited in the			disciplines involved. The		
	rian of care.				discipline were also reviewed		
	2 G1: : 1	1.111			document coordination of care		
		rd #1, start of care (SOC)			their submitted visit notes. The Director of Nursing is responsi		
	•	evidence coordination of			for monitoring these corrective		
	care with any oth	ner agency or service for			actions to ensures to ensure the		
	homemaking.				this deficiencies is corrected a		
					will not recur.		
	a. On 12/11.	/12 at 10:05 AM, patient					
	#1 indicated homemaker services were						
	provided by anot						
	provided by affol	inci agency.					

State Form Event ID: SRH111 Facility ID: 011123 If continuation sheet Page 44 of 62

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE COMPI	
ANDILAN	OF CORRECTION	157592	A. BUILDING	00		/2012
		137392	B. WING			72012
NAME OF F	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD	DΕ	
LMR IND	IANA HOME CARE	INC		BROADWAY STE 1 RILLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPL	LD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
TAG	b. On 12/11 director of nursing medical purpose services. 3. Clinical recordany communicate regarding another home health aided as On 12/12/caregiver of patienaide and homem another home health aided aid	/12 at 3:55 PM, the ng indicated there was no for the homemaker ad #6 failed to evidence ion or other information or home agency providing to or homemaker service. 12 at 1:45 PM, the lent #6 indicated receiving aker services from	TAG	DEFICIENCY		DATE
	connection betw	een the arterial and				
		oply for hemodialysis)				
	_	ne patient received				
	-	here record failed to				
		led nurse communicated				
	with the dialysis	tacility.				
		at 2:30 PM, the director atted the patient's record				

State Form Event ID: SRH111 Facility ID: 011123 If continuation sheet Page 45 of 62

PRINTED: 01/03/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157592	B. WING		12/13/2012
	PROVIDER OR SUPPLIE		STREET 7101 B	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 ILLVILLE, IN 46410	•
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
PREFIX	(EACH DEFICIENT REGULATORY OF did not indicate	ncy must be preceded by full R LSC IDENTIFYING INFORMATION) the skilled nurse had with the dialysis clinic	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION

State Form Event ID: SRH111 Facility ID: 011123 If continuation sheet Page 46 of 62

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPL	ETED
		157592				12/13/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L					
I MD IND	IANA HOME CARE	INC			ROADWAY STE 1 LLVILLE, IN 46410		
LIVIR IND	IANA HOME CARE	INC		MEKKI	LLVILLE, IN 404 IU		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
N0522	410 IAC 17-13-1(a)					
	Patient Care						
	Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician,						
	•						
	dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review,						
			N05	522	The Director of Nursing has		01/02/2013
		· ·	1,00	- 	inservices all staff on		01/02/2013
	personnel file review, and interview, the agency failed to ensure treatments were				01/02/2013. Reviewed and		
	0 3				discussed agency policy on		
	provided as ordered on the plan of care for 2 of 12 records reviewed (#2 and 4) with the potential to affect all patients of				following plan of care and		
				treatment. Job description reviewed.All staff were inserviced and 1:1 training was given on			
	the agency.				Policy regarding Plan of		
					Treatment. Also, Skilled Nurs	е	
	Findings				job description was reviewed and		
	C				all staff were inserviced on wo		
	1 Clinical recor	rd #2, SOC 9/28/12,			documentation and proper use		
	included a plan of				skilled nursing notes to docum		
	•				wound.The Director of Nursing	-	
		od of 9/28/12 - 11/26/12			will be responsible for monitor these corrective actions to ens	-	
		dence orders for oxygen			that this deficiencies is correct		
	saturation monitor	_			and will not recur.	.cu	
	documented at sl	killed nurse visits.			G. 10 11 11 11 11 11 11 11 11 11 11 11 11		
	a. A start of	Care initial assessment					
	visit on 9/28/12	and signed by Employee					
		arse (RN), stated,					
		ion 96 % ra [room air].					
	OAYGON Saturati	1011 70 70 10 [100111 att].					
	1. A	-i-i4i41 - data - C10/2/12					
		visit with a date of 10/2/12					
		mployee B stated,					
	"Oxygen saturati	ion 96%."					
	c. On 12/12	/12 at 3:30 PM, the					
		ng indicated the plan of					
		1					

State Form Event ID: SRH111 Facility ID: 011123 If continuation sheet Page 47 of 62

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		157592	B. WIN			12/13/	2012
NAME OF I	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
LMDIND	NAMA LIOME OADE	- INO			ROADWAY STE 1		
LIVIR INL	IANA HOME CARE	: INC		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		ers for the oxygen		IAG			DATE
		be monitored at skilled					
	nurse visits.	o de monitorea at skinea					
	nuise visits.						
	2. Clinical reco	rd #4, start of care					
		d a plan of care for the					
	certification period of 11/18/12 -						
		an order for silvadene					
		lied to bilateral lower					
	extremities, the area to be covered with non-stick pads and kerlix, and secured in place with tape. The dressing change was						
	to be completed	every day with the wound					
	_	ith 0.9% normal saline					
	prior to applicati	ion of the new dressing.					
		anges were to start					
	10/10/12.						
	a. A clinica	l record document titled					
	"Skilled Nursing	g Visit Note" with					
	signature of Emp	ployee E, dated 12/5/12					
	at 9:30 (lacked t	he specification if this					
		or P.M.) failed to include					
	1 -	ion that wound care was					
	_	e wound was assessed or					
	measured.						
		3/12 at 10:30 AM, the					
		ng indicated the wound					
	care was not cor	mpleted on this visit note.					
	<i>5</i>	1 C1 F 1 4 C1 :					
		el file E, date of hire					
		nced a job description for					
	Home Health Ni	urse: Registered Nurse					

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PRINTED: 01/03/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592		A. BUILDING B. WING	00	COMPLETED 12/13/2012	
	ROVIDER OR SUPPLIER		7101 BI	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	12/30/07. This jurishing in the process to assess evaluate patient sphysician's planer Responsibilities provides direct provid	Implementation atient care with clinical ording to the plan of			

State Form Event ID: SRH111 Facility ID: 011123 If continuation sheet Page 49 of 62

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157592			(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/13/2012
	ROVIDER OR SUPPLIER		710	EET ADDRESS, CITY, STATE, ZIP CODE 11 BROADWAY STE 1 RRILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION DATE
N0524	plan of care shall (A) Be developed home health ager (B) Include all se skilled service is I (B) Cover all peri (C) Include the for (i) Mental statu (ii) Types of se required. (iii) Frequency a (iv) Prognosis. (v) Rehabilitatio (vi) Functional I (vii) Activities per (viii) Nutritional re (ix) Medication (x) Any safety against injury. (xi) Instructions referral. (xii) Therapy montreatment. (xiii) Any other approach and the agency failed contained all mesurgical procedure patient received (Clinical records).	(1) As follows, the medical din consultation with the ney staff. Invices to be provided if a peing provided. Sinent diagnoses. Sollowing: Us. Invices and equipment and duration of visits. In potential. Similations. In potential. Similations. In measures to protect and treatments. In the plan of care dications, equipment, res, and all services the for 2 of 9 active records #1 and #7) reviewed intial to affect all of the	N0524	Director of Nursing has inservation of 1/02/2013 on following: The medical plan of care and ensure that staff developes plan accurately arpertinent diagnosis including mental status. Types of service and equipment frequency and duration of visits Prognosis, Rehab potential functional limitations, activities permitted nutritional requirements, safe measures to protect against injury. Instructions for dischautherapy modalities and length	nd all ces d ty rge,

State Form Event ID: SRH111 Facility ID: 011123 If continuation sheet Page 50 of 62

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		157592	B. WIN	IG		12/13/2012
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	KOVIDEK OK SUPPLIER			7101 BF	ROADWAY STE 1	
LMR IND	IANA HOME CARE	INC		MERRII	LLVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
		d #1, Start of care (SOC)			treatment at any other appropriate items. The Director	of
	·	a plan of care for the			Home Helath care services	
	_	od of 10/30/12 - 12/28/12			services will be responsible for monitoring these corrective	-
		dence the patient had an				
	oxygen concentrator as needed for use for				actions to ensure that this	
	shortness of brea	ith.			deficiency is corrected and will not recur.	
					not room.	
	a. On 12/11/12 at 10 AM, patient #1					
	was observed to have an oxygen					
	concentrator in the home.					
		'12 at 10:05 AM, patient				
		ng oxygen when it was				
		cold outside or if needed				
	for shortness of l	breath.				
	0 12/11	/10 / 2 20 PM / 1				
		/12 at 3:30 PM, the				
		ng indicated the oxygen				
	use was not on tl	ne plan of care.				
	2 Clinical reco	rd #7, start of care				
		d a plan of care for the				
		od of 9/10/12 - 11/8/12				
		dence the patient had an				
		AV) fistula in the right				
		d hemodialysis 3 days a				
	week.	i hemodiarysis 3 days a				
	WCCK.					
	Δ Δ clinics	al record document titled				
		alt to Case Management"				
		26/12 from a local				
		Renal dialysis status right				
	_					
	upper arm AV fi	Siuia.				

State Form Event ID: SRH111 Facility ID: 011123 If continuation sheet Page 51 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING (COMPLETED					
		157592	A. BUI B. WIN			12/13/	2012
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	B. On 8/24/ of nursing indica hemodialysis at a times a week. T address the AV t hemodialysis can three times a wee 3. The agency p treatment" with a stated, "A plan of for each patient a health program i referring physici treatment incli information su medical supplies medical equipment	112 at 3 PM, the director ated the patient was on a dialysis clinic three the plan of care did not fistula or the re the patient received					

State Form Event ID: SRH111 Facility ID: 011123 If continuation sheet Page 52 of 62

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	DNSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		157592	B. WIN			12/13/	2012
			b. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
I MD IND	IANA HOME CARE	INC			ROADWAY STE 1 LLVILLE, IN 46410		
LIVIR IIVD	IANA HOME CARE	INC		MEKKI	LLVILLE, IN 404 IU		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
N0537	410 IAC 17-14-1(•					
	Scope of Services						
		The home health agency					
	shall provide nurs						
	_	or a licensed practical					
	care as follows:	nce with the medical plan of					
		I record raviaw	N05	27	Administrator and Director of		01/02/2013
	Based on clinical record review,		1103	151	Administrator and Director of Nursing inserviced staff 01/02/13		01/02/2013
	_	view, and interview, the			, on scope of services and	10	
		ensure the registered			following plan of care and for		
	nurse provided to	reatments as ordered on			proper documentation and pla	n of	
the plan of care for 2 of 1 reviewed (#2 and 4) with		for 2 of 12 records			care will be followed and		
		d 4) with the potential to			implemented and evaluate pat	tient	
, the state of the	s of the agency receiving			services based upon Physicial	n		
				plan of treatment.Director of			
	Skilled Hurse Serv	vices.			Home Health care services wi		
					responsible for monitoring the		
	Findings				corrective actions to ensure the this deficiency is corrected and		
					will not recur.	J	
	 Clinical recor 	d #2, SOC 9/28/12,			wiii flot recur.		
	included a plan of	of care for the					
	•	od of 9/28/12 - 11/26/12					
	_	dence orders for oxygen					
	saturation monito	_					
	documented at sl	killed nurse visits.					
	a. A start of	care initial assessment					
	visit on 9/28/12 a	and signed by Employee					
	B, Registered Nu	irse (RN), stated,					
	<u>-</u>	on 96 % ra [room air].					
	Ong gon saturati	on 20 70 tu [room un].					
	h / m	vigit with a data of 10/2/12					
		visit with a date of 10/2/12					
		nployee B stated,					
	"Oxygen saturation 96%."						
	c. On 12/12	/12 at 3:30 PM, the					
		,					

State Form Event ID: SRH111 Facility ID: 011123 If continuation sheet Page 53 of 62

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		157592	B. WIN	IG		12/13/	2012
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	KOVIDEK OK SUPPLIER			7101 BF	ROADWAY STE 1		
LMR IND	IANA HOME CARE	EINC		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ng indicated the plan of					
	care lacked orde	rs for the oxygen					
	saturation rate to	be monitored at skilled					
	nurse visits.						
		rd #4, start of care					
	5/22/12 included a plan of care for the						
	certification period of 11/18/12 -						
	1/16/2013, with an order for silvadene						
cream to be applied to bilateral lower							
	extremities, the area to be covered with						
	non-stick pads and kerlix, and secured in						
	place with tape.	The dressing change was					
	to be completed	every day with the wound					
	being cleaned w	ith 0.9% normal saline					
	prior to applicati	ion of the new dressing.					
	The dressing cha	anges were to start					
	10/10/12.						
	a. A clinica	l record document titled					
	"Skilled Nursing	g Visit Note" with					
	signature of Emp	ployee E, dated 12/5/12					
	at 9:30 (lacked the	he specification if this					
	time was A.M. o	or P.M.) failed to include					
	any documentati	on that wound care was					
	1 -	e wound was assessed or					
	measured.						
	b. On 12/13	3/12 at 10:30 AM, the					
	director of nursi	ng indicated the wound					
		npleted on this visit note.					
		l file E, date of hire					
	10/30/07, eviden	nced a job description for					

State Form Event ID: SRH111 Facility ID: 011123 If continuation sheet Page 54 of 62

PRINTED: 01/03/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		157592	B. WING		12/13/2012	
N				ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIE	K		ROADWAY STE 1		
	IANA HOME CARI		MERR	ILLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE CONTINUE	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		urse: Registered Nurse				
	with the signature of Employee E on					
	l '	job description stated,				
	_	ion: provides nursing care				
	to assigned patients utilizing the Nursing					
	process to assess, plan, implement and					
	evaluate patient services based upon a					
	physician's plan					
	_	Implementation				
		patient care with clinical				
	competence according to the plan of					
	· ·	ng care plan and				
		dards observes and				
	_	t's status and progress				
	_	outcomes administers				
		l treatments as prescribed				
	by the patient's	physician or podiatrist."				

State Form Event ID: SRH111 Facility ID: 011123 If continuation sheet Page 55 of 62

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		157592				12/13/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
I MD IND	IANA HOME CARE	inc			ROADWAY STE 1 LLVILLE, IN 46410		
LIVIR IIVD	IANA HOWE CARE	INC		MEKKI	LLVILLE, IN 404 IO		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
N0540	410 IAC 17-14-1(
	Scope of Services						
		(1)(A) Except where					
	services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. Based on clinical record review, interview, and policy review, the agency						
			N05	540	The Director of Nursing		01/02/2013
			110.	, 10	inserviced staff on scope of		01/02/2013
					inservices to properly docume	nt	
					and assess patients upon initia		
failed to ensure th accurately assesse arteriovenous fistu		_			assessment, Re-certification a	nd	
		sed the patient's			Resumption of Care. The initial		
		tula history during the			visit will be made by a Registe		
	initial assessmen	t and completed the			Nurse who will make a nursing		
	initial assessmen	at within 48 hours of			assessment of the patient and obtain their health and social		
	referral for 2 of 1	12 records reviewed			history within 48 hours of		
) with the potential to			receiving referral.The Director	of	
	-	-			Home Helath care services wil		
	affect all patients	s of the agency.			responsible for monitoring the	se	
					corrective actions to ensure th	at	
	Findings				this deficiency is corrected and	b	
					will not recur.		
	1. Clinical reco	rd #7, start of care					
	9/10/12, evidenc	ed the patient had a					
	· ·	petes mellitus type 2 and					
	U	lisease. The patient's					
	•	•					
		t failed to document the					
	-	(arteriovenous) fistula in					
	-	l a past history of AV					
	fistula in the left	arm.					
	a. A clinical	I record document titled					
	"Patient # 7 Southlake" stated, "Emergency room admit date 9/24/12 and						
	discharge date 9/	/26/12 past surgical					
							l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURV COMPLETEI 12/13/201	D	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	R		ROADWAY STE 1		
LMR IND	IANA HOME CARE	EINC		ILLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP		MPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		is fistula creation multiple				
	right upper arm.	history both arms last one				
	rigiit upper ariii.					
	b. On 12/11	/12 at 2:30 PM,				
		e director of nursing,				
	indicated the initial assessment had not included the AV fistula history. c. The agency policy titled "Admission" with a review date of 8/6/12 stated, "The initial visit will be made a					
	_	e who will make a				
		ent of the patient and				
		th and social history				
	within 48 hours	of receiving referral."				
	2. Clinical recor	d #9, Start of care				
		eed a referral on 4/17/12				
	· ·	nd comprehensive				
	assessment on 4	/20/12.				
		cy policy titled				
		th a review date of 8/6/12				
		ial visit will be made by a				
		e who will make a				
	_	ent of the patient and				
		th and social history				
	within 48 hours	of receiving referral."				
	b. On 12/13	3/12 at 3:38 PM, the				
		ng indicated the initial				
		not completed within 48				
	hours.					

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		IDENTIFICATION NUMBER: 157592	(X2) MULTIPLE CO A. BUILDING B. WING	00				
LMR IND	ROVIDER OR SUPPLIER	INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7101 BROADWAY STE 1 MERRILLVILLE, IN 46410					
	IANA HOME CARE SUMMARY S' (EACH DEFICIEN		STREET A 7101 BF	ROADWAY STE 1	DDE RECTION OULD BE	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592			LDING	ONSTRUCTION 00	(X3) DATE (COMPL 12/13 /	ETED	
	ROVIDER OR SUPPLIER		B. WIIV	7101 BF	ADDRESS, CITY, STATE, ZIP CODE ROADWAY STE 1 LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
N0545	services are limite purposes of pract setting, the regist following: (F) Coordinate set set in the purpose of practical record responsible to ensure the register care with other effor 3 of 3 (clinical #7) records revies services from oth potential to affect services from an Findings 1. The agency prof Patient services shall matched the following services shall matched the potential to affect services shall matched the plan of care." 2. Clinical records/3/12, failed to 5/3/12, failed to 5/3/	ed to therapy only, for ice in the home health ered nurse shall do the ervices. ew, policy review, and eview, the agency failed istered nurse coordinated nutities providing services all record #1 and #6 and ewed of patients receiving her entities with the et all patients receiving	N0:	545	The Director of Nursing has inserviced staff on Coordination of Services. All personal furnishing services shall maint a liaison to assure their efforts are coordinated effectively and support the objectives outlined the plan of care. All Homemal services must be coordinated and documented in chart. Skille Nurse must coordinated care of dialysis center. The Director of Home Health Care services where the esponsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	ain d d in ker with ed with of ill	01/02/2013

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPI	
		157592	B. WING		12/13	/2012
NAME OF I	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP CODE		
LMD IND	NAMA HOME CADE	INO		ROADWAY STE 1		
LMR INL	DIANA HOME CARE	: INC	MERRI	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		/12 at 10:05 AM, patient				
		nemaker services were				
	provided by ano	ther agency.				
		/12 at 3:55 PM, the				
	director of nursi	ng indicated there was no				
	medical purpose	for the homemaker				
	services.					
	3. Clinical record #6 failed to evidence any communication or other information					
regarding another home agency providing						
	home health aide or homemaker service.					
	a. On 12/12/	12 at 1:45 PM, the				
	caregiver of pati	ent #6 indicated receiving				
		aker services from				
	another home he	ealth agency.				
		5 3				
	b. On 12/13/	/12 at 11:05 AM, the				
	director of nursi	ng indicated patient #6				
		ervices from another				
	_	as not documented.				
	4 Clinical reco	rd #7, start of care				
		eed the patient had				
	· ·	lisease and a right arm				
		AV) fistula (surgical				
	`	reen the arterial and				
		pply for hemodialysis)				
		ne patient received				
	_	here record failed to				
	_	lled nurse communicated				
	with the dialysis	racility.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 157592	A. BUILDING B. WING		COMF	E SURVEY PLETED 3/2012
NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7101 BROADWAY STE 1 MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE COMPLETION	
	of nursing indicated	at 2:30 PM, the director ated the patient's record the skilled nurse had with the dialysis clinic the care.				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157592 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE				
157592 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	2012			
STREET ADDRESS, CITY, STATE, ZIP CODE	12/13/2012			
NAME OF PROVIDER OR SUPPLIER				
7101 BROADWAY STE 1	7101 BROADWAY STE 1			
LMR INDIANA HOME CARE INC MERRILLVILLE, IN 46410				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE			
N0550 410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.	01/02/2013			

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